MEDICAID WORKS
Agreement

I, _____, want to enroll in ***MEDICAID WORKS,*** the

PRINT ENROLLE NAME

work incentive plan for individuals with disabilities through the Virginia Medicaid program. I understand that this is a voluntary option and that I may leave the plan at any time and return to regular Medicaid coverage if I continue to meet the eligibility requirements for another Medicaid covered group.

I know that I must be employed to be enrolled in ***MEDICAID WORKS*** and that a monthly premium payment may be required to continue to participate in this plan. I understand that I must establish at least one Work Incentive (WIN) account at a bank or other financial institution to be eligible for this work incentive plan and that I must deposit all earned income into a WIN account. Through the WIN account, I can have earnings in 2007 of up to $40,905. If I am going to save some of my earnings, I must keep it in a WIN account, where I can save up to $27,577 in 2007.

I agree to the above requirements for ***MEDICAID WORKS*** and to inform my eligibility worker about changes that may affect my coverage, including but not limited to, change of address, change in employment or loss of employment. I further agree to provide any required documentation regarding my employer, employment status, earned income and WIN account(s).

_____ _____

Print Full Name Social Security Number

_____ _____

Signature Date

Prepared by the Virginia Department of Medical Assistance Services, effective January 24, 2007